FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039115

Facility Name: Wheaton Care Center

Address: 1325 Manchester Road (Number) Wheaton (City) 60187 (Zip Code)

County: Dupage

Telephone Number: (630) 668-2500 **Fax #** (630) 668-0232

IDPA ID Number: 363905787001

Date of Initial License for Current Owners: 09/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	30,012	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	15,006	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,966	250	377	4,593	8
9	SNF/PED					9
10	ICF	35,692	2,250	27	37,969	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,658	2,500	404	42,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.54%

D. How many bed-hold days during this year were paid by Public Aid?
650 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 81 and days of care provided 377

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	215,019	23,488	12,140	250,647		250,647	(2,347)	248,300			1
2	Food Purchase		165,770		165,770		165,770	(5,965)	159,805			2
3	Housekeeping	143,393	20,173	100	163,666		163,666	(2,804)	160,862			3
4	Laundry	36,826	15,435	505	52,766		52,766	(10)	52,756			4
5	Heat and Other Utilities			128,320	128,320		128,320	1,064	129,384			5
6	Maintenance	48,277		119,672	167,949		167,949	3,638	171,587			6
7	Other (specify):*							1,307	1,307			7
8	**TOTAL General Services**	443,515	224,866	260,737	929,118		929,118	(5,117)	924,001			8
	B. Health Care and Programs											
9	Medical Director			1,250	1,250		1,250		1,250			9
10	Nursing and Medical Records	1,499,221	21,508	26,765	1,547,494		1,547,494	10,296	1,557,790			10
10a	Therapy	33,485		180	33,665		33,665		33,665			10a
11	Activities	99,710	10,270	2,544	112,524		112,524		112,524			11
12	Social Services	185,964	235	4,830	191,029		191,029	7,651	198,680			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,793	3,793			15
16	**TOTAL Health Care and Programs**	1,818,380	32,013	35,569	1,885,962		1,885,962	21,740	1,907,702			16
	C. General Administration											
17	Administrative	84,371		5,079	89,450		89,450	9,808	99,258			17
18	Directors Fees											18
19	Professional Services			246,058	246,058		246,058	(173,440)	72,618			19
20	Dues, Fees, Subscriptions & Promotions			25,604	25,604		25,604	(12,186)	13,418			20
21	Clerical & General Office Expenses	56,401	10,801	143,656	210,858		210,858	(1,978)	208,880			21
22	Employee Benefits & Payroll Taxes			298,532	298,532		298,532	(4,944)	293,588			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,853	2,853		2,853	2,889	5,742			24
25	Other Admin. Staff Transportation			4,949	4,949		4,949		4,949			25
26	Insurance-Prop.Liab.Malpractice			135,898	135,898		135,898	632	136,530			26
27	Other (specify):*							16,718	16,718			27
28	**TOTAL General Administration**	140,772	10,801	862,629	1,014,202		1,014,202	(162,501)	851,701			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,402,667	267,680	1,158,935	3,829,282		3,829,282	(145,878)	3,683,404			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wheaton Care Center #0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,180	54,180		54,180	37,890	92,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,878	7,878		7,878	(7,878)				32
33	Real Estate Taxes			50,688	50,688		50,688	1,314	52,002			33
34	Rent-Facility & Grounds			662,160	662,160		662,160	3,622	665,782			34
35	Rent-Equipment & Vehicles			1,660	1,660		1,660	1,283	2,943			35
36	Other (specify):*			313	313		313		313			36
37	**TOTAL Ownership**			776,879	776,879		776,879	36,231	813,110			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,067	15,933	80,000		80,000	(22,394)	57,606			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,527	67,527		67,527		67,527			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		64,067	83,460	147,527		147,527	(22,394)	125,133			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,402,667	331,747	2,019,274	4,753,688		4,753,688	(132,041)	4,621,647			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	26,700	30		9
10	Interest and Other Investment Income	(7,958)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(97)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	21		24
25	Fund Raising, Advertising and Promotional	(1,049)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,165)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(90,850)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (118,419)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(13,621)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (13,621)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (132,041)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Wheaton Care Center
ID# 0039115
Report Period Beginning: 01/01/04
Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (4)	21	1
2	Patient Clothing	(308)	10	2
3	Theft Loss	(4,480)	21	3
4	Collection Expense	(37)	21	4
5	COPE Dues	(1,903)	20	5
6	PPA - Pharmacy	(13,906)	39	6
7	PPA - 401K	(1,984)	22	7
8	Capitalized R&M	(1,117)	6	8
9	Prior Year Legal Fees	(2,859)	19	9
10	Vending Income	(7,490)	02	10
11	Non-Allowable Expense	(56,762)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
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94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(90,850)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(87)	279		(1,950)	(589)				(2,347)	1
2	Food Purchase	(7,587)							1,622				(5,965)	2
3	Housekeeping				(2,804)								(2,804)	3
4	Laundry				(10)								(10)	4
5	Heat and Other Utilities					1,064							1,064	5
6	Maintenance	(1,117)			(192)	1,136		3,789	22				3,638	6
7	Other (specify):*						81	926	300				1,307	7
8	**TOTAL General Services**	(8,704)			(3,092)	2,479	81	2,765	1,355				(5,117)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(308)			(2,638)			13,242					10,296	10
10a	Therapy													10a
11	Activities													11
12	Social Services							7,651					7,651	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						736	3,057					3,793	15
16	**TOTAL Health Care and Programs**	(308)			(2,638)		736	23,950					21,740	16
	C. General Administration													
17	Administrative							9,662	146				9,808	17
18	Directors Fees													18
19	Professional Services	(2,859)				(170,596)			15				(173,440)	19
20	Fees, Subscriptions & Promotions	(2,952)				(9,242)			8				(12,186)	20
21	Clerical & General Office Expenses	(106,448)			(157)	10,376		93,986	265				(1,978)	21
22	Employee Benefits & Payroll Taxes	(1,984)		(401)			(2,559)						(4,944)	22
23	Inservice Training & Education													23
24	Travel and Seminar					2,823			66				2,889	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					576			56				632	26
27	Other (specify):*						1,679	15,039					16,718	27
28	**TOTAL General Administration**	(114,243)		(401)	(157)	(166,063)	(880)	118,687	556				(162,501)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(123,255)		(401)	(5,888)	(163,584)	(63)	145,402	1,911				(145,878)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	26,700				10,547				643			37,890	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,958)							8	72			(7,878)	32
33	Real Estate Taxes					1,314							1,314	33
34	Rent-Facility & Grounds					3,317			305				3,622	34
35	Rent-Equipment & Vehicles					1,276			7				1,283	35
36	Other (specify):*													36
37	**TOTAL Ownership**	18,742				16,454			320	715			36,231	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(13,906)			(2,282)				(4,876)	(1,330)			(22,394)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(13,906)			(2,282)				(4,876)	(1,330)			(22,394)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(118,419)		(401)	(8,169)	(147,130)	(63)	145,402	(2,645)	(615)			(132,041)	45

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 73,808	$ 73,808	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	74,209	CCS EMPLOYEE BENEFIT GROUP	100.00%		(74,209)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,209			$ 73,808	$ * (401)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 586	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 499	$ (87)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	18,899	XCEL MEDICAL SUPPLY, LLC	100.00%	16,095	(2,804)	17
18	V	04	LAUNDRY	64	XCEL MEDICAL SUPPLY, LLC	100.00%	55	(10)	18
19	V	06	REPAIRS & MAINTENANCE	1,294	XCEL MEDICAL SUPPLY, LLC	100.00%	1,102	(192)	19
20	V	10	NURSING	17,782	XCEL MEDICAL SUPPLY, LLC	100.00%	15,144	(2,638)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE	1,060	XCEL MEDICAL SUPPLY, LLC	100.00%	903	(157)	23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY	15,379	XCEL MEDICAL SUPPLY, LLC	100.00%	13,097	(2,282)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 55,064			$ 46,895	$ * (8,169)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 279	$ 279	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,064	1,064	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,136	1,136	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	176,324	Care Centers, Inc.	100.00%	5,728	(170,596)	20
21	V	20	Dues and Subscriptions	11,224	Care Centers, Inc.	100.00%	1,982	(9,242)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	10,376	10,376	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	2,823	2,823	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	576	576	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	10,547	10,547	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,314	1,314	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,317	3,317	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,276	1,276	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 187,548			$ 40,418	$ * (147,130)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 550	Care Centers, Inc.	100.00%	$ 550	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	81	81	16
17	V	10	Nursing Salary	2,486	Care Centers, Inc.	100.00%	2,486		17
18	V	10a	Rehab Salary	180	Care Centers, Inc.	100.00%	180		18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary	2,367	Care Centers, Inc.	100.00%	2,367		20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	736	736	21
22	V	17	Administration Salary	1,841	Care Centers, Inc.	100.00%	1,841		22
23	V	21	Office Salary	9,637	Care Centers, Inc.	100.00%	9,637		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	1,679	1,679	24
25	V	22	Employee Benefits	2,559	Care Centers, Inc.	100.00%		(2,559)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 19,620			$ 19,557	$ * (63)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 4,490	Care Centers, Inc.	100.00%	$ 2,540	$ (1,950)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	3,789	3,789	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	926	926	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	13,242	13,242	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	7,651	7,651	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,057	3,057	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	9,662	9,662	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	93,986	93,986	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	15,039	15,039	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,490			$ 149,892	$ * 145,402	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 3,205	Care Centers, Inc. - Health Systems Division	100.00%	$ 568	$ (2,637)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,622	1,622	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	22	22	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	146	146	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	15	15	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	8	8	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	265	265	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	66	66	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	56	56	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	8	8	24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	305	305	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	7	7	26
27	V	39	Ancillary Enteral Supplies	9,874	Care Centers, Inc. - Health Systems Division	100.00%	4,998	(4,876)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,048	2,048	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	300	300	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,079			$ 10,434	$ * (2,645)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 643	$ 643	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	72	72	16
17	V	39	Vent Reimbursement	1,330	Vent Lease, LLC.	100.00%		(1,330)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,330			$ 715	$ * (615)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Eric Rothner	Owner	Administrative	21.95%	See Attached	0.90	1.95%	Mgmt Fees	$ 3,238	17-3	1
2	Adam Vales	Relative	Clerical		See Attached	0.48	1.20%	Alloc. Salary	498	22-7	2
3	Norman Goldberg	Owner	Administrative	4.07%	See Attached	1.00	2.00%	Alloc. Salary	2,697	17-7	3
4	Mark Steinberg	Relative	Administrative		See Attached	1.50	2.73%	Alloc. Salary	1,733	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 8,166		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 WEST MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 73,808	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 73,808	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 499	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						16,095	3
4	04	LAUNDRY	Direct Allocation						55	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						1,102	5
6	10	NURSING	Direct Allocation						15,144	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation						903	9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation						13,097	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 46,895	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	42,562	$ 279	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		42,562	1,064	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		42,562	1,136	3
4	10	Nursing	Patient Days	1,484,397	42			42,562		4
5	11	Activities	Patient Days	1,484,397	42			42,562		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		42,562	5,728	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		42,562	1,982	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		42,562	10,376	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		42,562	2,823	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		42,562	576	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		42,562	10,547	11
12	32	Interest	Patient Days	1,484,397	42			42,562		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		42,562	1,314	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		42,562	3,317	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		42,562	1,276	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 40,418	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		550	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			81	2
3	10	Nursing Salary	Direct Cost			209,584	209,584		2,486	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982		180	4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710		2,367	6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			736	7
8	17	Administration Salary	Direct Cost			38,431	38,431		1,841	8
9	21	Office Salary	Direct Cost			525,935	525,935		9,637	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			1,679	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 19,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	42,562	2,540	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			42,562		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	42,562	3,789	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		42,562	926	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	42,562	13,242	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			42,562		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	42,562	7,651	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		42,562	3,057	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	42,562	9,662	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	42,562	93,986	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		42,562	15,039	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 149,892	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		13,079	568	1
2	02	Food	Billable Income	2,144,835		987,169		13,079	1,622	2
3	06	Maintenance	Billable Income	2,144,835		3,597		13,079	22	3
4	17	Administration	Billable Income	2,144,835		24,000		13,079	146	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		13,079	15	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		13,079	8	6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		13,079	265	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		13,079	66	8
9	26	Insurance	Billable Income	2,144,835		9,262		13,079	56	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		13,079	8	10
11	34	Rent - Building	Billable Income	2,144,835		50,000		13,079	305	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		13,079	7	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		13,079	4,998	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	13,079	2,048	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		13,079	300	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 10,434	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	$ 300,000	$	1,330	$ 643	1
2	32	Interest	Direct Billing	620,670	29	33,493		1,330	72	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 333,493	$		$ 715	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Premier Bank		X	Vehicle			$	$ 7,622			$ 765	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	CIB Bank										7,113	6
7	Alloc from Care Centers		X								8	7
8	See Supplemental Schedule										72	8
9	TOTAL Facility Related						$	$ 7,622			$ 7,958	9
	B. Non-Facility Related*											
10	Interest Income										(7,958)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (7,958)	14
15	TOTALS (line 9+line14)						$	$ 7,622			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc from Vent Lease		X				$	$			$ 72	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										72	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Wheaton Care Center **#** 0039115 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	53,087	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	51,936	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,151)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	53,153	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	52,002	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	49,738	8
	2000	50,704	9
	2001	49,393	10
	2002	50,559	11
	2003	50,622	12

2004 Accrual = $50,622 x 1.05 = $53,153

Care Centers allocation $1314

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-17-114-010	Long Term Care Property	$ 50,622.10	$ 50,622.10
2.	See Attached	Home Office Allocation	$ 106,873.39	$ 1,314.31
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 157,495.49	$ 51,936.41

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	2201 Main LLC - allocation			$ 10,084	1
2					2
3	TOTALS			$ 10,084	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	41,331		20	2,067	2,067	23,463	9
10	Various			1994	104,965		20	5,250	5,250	56,049	10
11	Various			1995	16,968		20	849	849	8,289	11
12	Various			1996	158,287		20	7,915	(7,915)	67,440	12
13	Various			1997	103,690		20	5,187	5,187	39,342	13
14	Various			1998	56,873		20	2,846	2,846	18,129	14
15	Various			1999	21,286		20	1,066	1,066	5,896	15
16	Various			2000	57,068		20	2,925	2,925	15,720	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
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64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		38,905	1,597		1,597		2,539	68
69	Financial Statement Depreciation			19,748			(19,748)		69
70	TOTAL (lines 4 thru 69)		$ 599,373	$ 21,345		$ 29,702	$ (7,473)	$ 236,867	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 599,373	$ 21,345		$ 29,702	$ 8,357	$ 236,867	1
2	Faucet And Sink	2001	780		20	39	39	156	2
3	Wall Mount Overlap C	2001	3,798		20	190	190	760	3
4	Exhaust Duct Work	2001	832		20	42	42	167	4
5	Nurse Call System	2001	1,800		20	90	90	360	5
6	Power Rod Maine Line	2001	813		20	41	41	163	6
7	Hot Water Supply Rep	2001	1,434		20	72	72	281	7
8	Voice Mail Supply Re	2001	2,488		20	124	124	487	8
9	Drapes	2001	10,722		20	536	536	2,099	9
10	Fire/Alarm Equip-Win	2001	3,013		20	151	151	578	10
11	Install New Drapes &	2001	1,920		20	96	96	368	11
12	Sprinkler System Rep	2001	1,250		20	63	63	241	12
13	Sewer Line	2001	2,165		20	108	108	406	13
14		2001	599		20	30	30	113	14
15	Boiler Room Flow Val	2001	825		20	41	41	155	15
16	Electrical Renovatio	2001	943		20	47	47	172	16
17	Door Closers	2001	569		20	28	28	104	17
18	Electrical Renovatio	2001	550		20	28	28	102	18
19	Repr/Damg/Mising Shg	2001	500		20	25	25	92	19
20	Install Key Cylinder	2001	1,041		20	52	52	191	20
21	Hvac	2001	981		20	49	49	180	21
22	Plumbing	2001	1,563		20	78	78	280	22
23	Painting	2001	719		20	36	36	129	23
24	Wining	2001	575		20	29	29	101	24
25	Plumbing	2001	691		20	35	35	122	25
26	P/A System	2001	1,199		20	60	60	210	26
27	A/C Repair	2001	669		20	67	67	229	27
28	Masonry	2001	1,600		20	80	80	260	28
29	Hvac	2001	691		20	35	35	113	29
30	Plumbing	2001	1,240		20	62	62	202	30
31	Hvac	2001	641		20	32	32	104	31
32	Gutters	2001	575		20	58	58	182	32
33	Pa System	2001	1,096		20	110	110	393	33
34	TOTAL (lines 1 thru 33)		$ 647,655	$ 21,345		$ 32,236	$ 10,891	$ 246,367	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 647,655	$ 21,345		$ 32,236	$ 10,891	$ 246,367	1
2	Plumbing	2002	3,707		20	371	371	1,112	2
3	Door Systems	2002	2,810		20	281	281	843	3
4	Plumbing	2002	921		20	92	92	269	4
5	Paint	2002	628		20	63	63	183	5
6	Cabinets	2002	2,976		20	198	198	562	6
7	Boiler	2002	1,716		20	172	172	472	7
8	Hvac	2002	759		20	76	76	183	8
9	Carpeting	2002	1,526		20	218	218	509	9
10	Boiler	2002	700		20	58	58	131	10
11	Hvac	2003	683		20	68	68	137	11
12	Freezer Relay Switch	2003	517		20	34	34	69	12
13	Repair Emergency Electric System	2003	595		20	30	30	55	13
14	Fire Alarm Repair	2003	522		20	75	75	131	14
15	Elijer Wall Mount Toilet	2003	525		20	26	26	46	15
16	Walk-In Freezer	2003	698		20	35	35	58	16
17	Sprinkler Repair	2003	679		20	97	97	154	17
18	A/C Repair	2003	941		20	78	78	124	18
19	Hvac	2003	2,396		20	479	479	719	19
20	Sprinkler System Repair	2003	878		20	44	44	55	20
21	6Ft High Fence	2003	6,126		20	613	613	766	21
22	Sprinkler System Repair	2003	2,160		20	309	309	360	22
23	Cement Drain And Pit	2003	1,580		20	158	158	184	23
24	3 New Doors	2004	2,880		20	288	288	288	24
25	Pyro-Chem Kitchen System *	2004	1,985		20	199	199	199	25
26	Smoke Detectors *	2004	1,059		20	212	212	212	26
27	Repair Boiler *	2004	895		20	179	179	179	27
28	Generator Repair *	2004	540		20	108	108	108	28
29	Ceiling Radiation Fire Dampers *	2004	845		20	169	169	169	29
30	Three Fire Dampers	2004	500		20	42	42	42	30
31	Gutters *	2004	4,100		20	342	342	342	31
32	Exhaust System	2004	3,290		20	274	274	274	32
33	Landscaping	2004	14,000		20	933	933	933	33
34	TOTAL (lines 1 thru 33)		$ 711,792	$ 21,345		$ 38,557	$ 17,212	$ 256,235	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 711,792	$ 21,345		$ 38,557	$ 17,212	$ 256,235	1
2	Repair Limestone Sill	2004	2,055		20	137	137	137	2
3	Interior Handrails	2004	1,636		20	109	109	109	3
4	Exterior Handrails	2004	9,600		20	640	640	640	4
5	Keypad *	2004	587		20	39	39	39	5
6	Fire Alarm System *	2004	43,000		20	2,867	2,867	2,867	6
7	Solenoid Valve *	2004	1,180		20	46	46	46	7
8	Diesel Generator *	2004	5,667		20	567	567	567	8
9	Cubicle Curtains *	2004	589		20	59	59	59	9
10	Wire Mesh *	2004	1,750		20	73	73	73	10
11	Sidewalk *	2004	1,400		20	58	58	58	11
12	Diesel Generator *	2004	5,667		20	472	472	472	12
13	Kitchen Grease Trap *	2004	2,200		20	73	73	73	13
14	Generator Project *	2004	5,667		20	378	378	378	14
15	Sales Tax On Generator *	2004	810		20	54	54	54	15
16	Sign *	2004	775		20	52	52	52	16
17	Electric Generator *	2004	5,921		20	197	197	197	17
18	Plumbing Repair *	2004	2,201		20	55	55	55	18
19	Repair Cooler In Kitchen *	2004	1,025		20	51	51	51	19
20	Installation Of Generator *	2004	5,146		20	43	43	43	20
21	Sprinkler System Service *	2004	615		20	5	5	5	21
22	Sprinkler Repair *	2004	2,100		20	18	18	18	22
23	Sprinkler Repair *	2004	2,500		20	21	21	21	23
24	Generator Service *	2004	762		20	13	13	13	24
25	Paint *	2004	553		20	23	23	23	25
26	Paint *	2004	564		20	9	9	9	26
27	* Added After 6/30/04 Capital Report	2004			20				27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 815,762	$ 21,345		$ 44,616	$ 23,271	$ 262,294	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC		2002		$ 13,897	$ 347	40	$ 347	$	$ 89	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	11,480	574	20	574		1,435	9
10	Allocation - 2201 Main LLC			2003	13,528	676	20	676		1,015	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 38,905	$ 1,597		$ 1,597	$	$ 2,539	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 338,472	$ 21,194	$ 31,209	$ 10,015	10	$ 224,772	71
72	Current Year Purchases	65,289	16,461	9,677	(6,784)	10	9,677	72
73	Fully Depreciated Assets	19,331				10	19,331	73
74								74
75	TOTALS	$ 423,092	$ 37,655	$ 40,886	$ 3,231		$ 253,780	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VAN	2003	$ 19,994	$ 4,900	$ 5,098	$ 198	5	$ 8,098	76
77		Care Centers Allocation		19,884	1,469	1,469		5	16,538	77
78										78
79										79
80	TOTALS			$ 39,878	$ 6,369	$ 6,567	$ 198		$ 24,636	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,288,816	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,369	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 92,069	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,700	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 540,710	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NWOS General Partnership

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 662,160			3
4	Additions							4
5	Allocated from Care Centers				3,622			5
6								6
7	TOTAL				$ 665,782 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,943 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 3,610	$		$ 3,610	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			404			404	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			11,919			11,919	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				27,764		27,764	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						36,303		36,303	13
14	TOTAL			$		$ 15,933	$ 64,067		$ 80,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,487	$	1
2	Cash-Patient Deposits	38,494		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	839,720		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	142,722		6
7	Other Prepaid Expenses	1,352		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	1,131,994		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,155,769	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	711,121		15
16	Equipment, at Historical Cost	433,236		16
17	Accumulated Depreciation (book methods)	(478,909)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	307,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 972,948	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,128,717	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 413,111	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,753		28
29	Short-Term Notes Payable	7,622		29
30	Accrued Salaries Payable	116,625		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,131		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,153		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	19,886		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 648,281	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 648,281	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,480,436	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,128,717	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,298,223	1	
2	Restatements (describe):		2	
3	**Depreciation**	36,376	3	
4	**Repairs & Maintenance**	(94)	4	
5	**Rounding**	5	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,334,510	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	145,926	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 145,926	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,480,436	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,753,533	1
2	Discounts and Allowances for all Levels	(33,668)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,719,865	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,283	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 44,283	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,348	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,686	19
20	Radiology and X-Ray	160	20
21	Other Medical Services	(377)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 29,817	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	98,155	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98,155	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,494	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,494	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,899,614	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	929,118	31
32	Health Care	1,885,962	32
33	General Administration	1,014,202	33
	B. Capital Expense		
34	Ownership	776,879	34
	C. Ancillary Expense		
35	Special Cost Centers	80,000	35
36	Provider Participation Fee	67,527	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,753,688	40
41	**Income before Income Taxes (line 30 minus line 40)****	145,926	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 145,926	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,109	2,551	$ 71,995	$ 28.22	1
2	Assistant Director of Nursing	2,507	2,709	78,814	29.09	2
3	Registered Nurses	11,323	12,557	345,468	27.51	3
4	Licensed Practical Nurses	13,382	14,849	348,250	23.45	4
5	Nurse Aides & Orderlies	48,992	51,843	619,378	11.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,965	2,428	33,485	13.79	8
9	Activity Director	1,859	2,022	25,518	12.62	9
10	Activity Assistants	10,167	10,673	74,192	6.95	10
11	Social Service Workers	11,193	12,629	185,964	14.73	11
12	Dietician					12
13	Food Service Supervisor	2,340	2,663	43,052	16.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,299	18,863	171,967	9.12	15
16	Dishwashers					16
17	Maintenance Workers	3,253	3,660	48,277	13.19	17
18	Housekeepers	16,018	17,062	143,393	8.40	18
19	Laundry	4,185	4,448	36,826	8.28	19
20	Administrator	1,975	2,260	84,371	37.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,305	5,637	56,401	10.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,994	2,264	24,650	10.89	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,122	1,178	10,666	9.05	33
34	TOTAL (lines 1 - 33)	156,988	170,296	$ 2,402,667 *	$ 14.11	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	171	$ 12,140	01-03	35
36	Medical Director	monthly	1,250	09-03	36
37	Medical Records Consultant	monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,753	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	2,544	11-03	44
45	Social Service Consultant	44	2,463	12-03	45
46	Other(specify)				46
47	Phsychiatrist		351	10-03	47
48	CCI - see attached		5,033	various	48
49	TOTAL (lines 35 - 48)	267	$ 29,662		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	373	$ 17,703	10-03	50
51	Licensed Practical Nurses	8	344	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	381	$ 18,047		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Aaron Adler (1/1/04-1/30/04)	Administrator	0	$ 7,504
Todd Tedrow (2/7/04-12/31/04)	Administrator	0	76,867
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,371

B. Administrative - Other

Description	Amount
Management Fees - Eric Rothner	$ 3,238
Administrator salary paid through Care Centers Inc.	1,841
TOTAL (agree to Schedule V, line 17, col. 3)	$ 5,079
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll	$ 7,644
Care Centers Inc.	Data Processing	4,428
Care Centers Inc.	Home Office Expense	103,320
Care Centers Inc.	Ancillary Admin. Services	14,760
Care Centers Inc.	Bookkeeping	25,092
Care Centers Inc.	Accounting	15,000
Frost, Ruttenberg & Rothblatt	Accounting	18,000
Care Centers Inc.	Legal	11,224
Various - see attached	Legal	26,945
Personnel Planners	Unemployment Consultant	840
Care Centers Inc.	Professional Fees	2,500
See Supplemetal Schedule		16,305
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 246,058

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,763
Unemployment Compensation Insurance	17,106
FICA Taxes	178,127
Employee Health Insurance	36,700
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	1,922
Holiday Expense	1,970
TOTAL (agree to Schedule V, line 22, col.8)	$ 293,588

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,318
Advertising: Employee Recruitment	3,156
Health Care Worker Background Check	
(Indicate # of checks performed 62)	875
Dues & Subscriptions	3,802
Licenses & Fees	1,277
Advertising & Promotion	12,273
Allocated from Care Centers	1,990
Less: Public Relations Expense	( )
Non-allowable advertising	(12,273)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,418

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,225
Educational Expense	1,628
Allocated from Care Centers	2,889
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,742

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $4,732**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,548** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67,527**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.